



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Health HEB

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-14-2611-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

April 23, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sine TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria."

Amount in Dispute: \$3,171.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the review by Coventry, reimbursement is not owed for the medical bill in dispute."

Response Submitted by: Downs & Stanford PC

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 10 – 13, 2013	Outpatient Hospital Services	\$3,171.50	\$2,955.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 1.4 – The procedure code is inconsistent with the modifier used or a required modifier is missing

Issues

1. Did the carrier support denial code?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?

4. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 4 – “The procedure code is inconsistent with the modifier used or a required modifier is missing.” In their position statement the respondent states, “Coventry, the bill review company for Respondent, opined that this medical bill was not paid due to an improper use of the CPT code 97001.” 28 Texas Administrative Code §134.403 (d) states in pertinent part, “For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section...” Review of the above mentioned code, “97001” finds the definition – “Physical therapy evaluation” and. Modifier GP – “Services delivered under an outpatient physical therapy plan of care.” Both the procedure code and modifier are valid codes and consistent in the outpatient setting in which they were billed. The carrier's denial is not supported. Therefore, the disputed services will be reviewed per applicable rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code J7060 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J7120, date of service July 12, 2013, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
 - Procedure code 36415, date of service July 12, 2013, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
 - Procedure code 80048, date of service July 12, 2013, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the

date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.63. 125% of this amount is \$14.54

- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.63. 125% of this amount is \$14.54
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.69. 125% of this amount is \$13.36
- Procedure code 85027, date of service July 12, 2013, has conflict edit based on National Correct Coding Initiatives with procedure code 85025 Separate payment is not recommended.
- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.40. 125% of this amount is \$6.75
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.25. 125% of this amount is \$10.31
- Procedure code 72100, date of service July 10, 2013, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.95. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.57. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$26.34. The non-labor related portion is 40% of the APC rate or \$18.38. The sum of the labor and non-labor related amounts is \$44.72. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$44.72. This amount multiplied by 200% yields a MAR of \$89.44.
- Procedure code 73560, date of service July 10, 2013, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.95. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.57. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$26.34. The non-labor related portion is 40% of the APC rate or \$18.38. The sum of the labor and non-labor related amounts is \$44.72. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$44.72. This amount multiplied by 200% yields a MAR of \$89.44.
- Procedure code 73590, date of service July 10, 2013, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.95. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.57. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$26.34. The non-labor related portion is 40% of the APC rate or \$18.38. The sum of the labor and non-labor related amounts is \$44.72. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$44.72. This amount multiplied by 200% yields a MAR of \$89.44.

- Procedure code 73702 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0333, which, per OPPS Addendum A, has a payment rate of \$329.34. This amount multiplied by 60% yields an unadjusted labor-related amount of \$197.60. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$188.79. The non-labor related portion is 40% of the APC rate or \$131.74. The sum of the labor and non-labor related amounts is \$320.53. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$320.53. This amount multiplied by 200% yields a MAR of \$641.06.
- Procedure code 10140 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0007, which, per OPPS Addendum A, has a payment rate of \$725.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$435.35. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$415.93. The non-labor related portion is 40% of the APC rate or \$290.23. The sum of the labor and non-labor related amounts is \$706.16. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$706.16. This amount multiplied by 200% yields a MAR of \$1,412.32.
- Procedure code 97001, date of service July 12, 2013, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest practice expense for this date. The rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2013 is \$73.88. This amount divided by the Medicare conversion factor of 34.023 and multiplied by the Division conversion factor of 55.3 yields a MAR of \$120.08
- Procedure code 96374, date of service July 10, 2013, is not separately payable with code 99284 based on NCCI Standards of medical / surgical practice. Review of documentation finds no modifier or documentation to support a separate and distinct procedure. Separate payment is not recommended.
- Procedure code 96375, date of service July 10, 2013, is not separately payable with code 10140 based on NCCI Standards of medical / surgical practice. Review of documentation finds no modifier or documentation to support a separate and distinct procedure. Separate payment is not recommended.
- Procedure code 96376, date of service July 10, 2013, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 99284, date of service July 10, 2013, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$229.37. This amount multiplied by 60% yields an unadjusted labor-related amount of \$137.62. This amount multiplied by the annual wage index for this facility of 0.9554 yields an adjusted labor-related amount of \$131.48. The non-labor related portion is 40% of the APC rate or \$91.75. The sum of the labor and non-labor related amounts is \$223.23. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$223.23. This amount multiplied by 200% yields a MAR of \$446.46.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170, date of service July 12, 2013, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the

reimbursement for other services, including outliers.

- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2001, date of service July 12, 2013, is unbundled. This procedure is a component service of procedure code 10140 performed on the same date. Payment for this service is included in the reimbursement for other services performed. A modifier is not allowed. Separate payment is not recommended.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3480 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code Q9967 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005 is not separately payable with code 10140 based on NCCI Standards of medical / surgical practice. Review of documentation finds no modifier or documentation to support a separate and distinct procedure. Separate payment is not recommended.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is \$2,955.24. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$2,955.24. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2,955.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,955.24, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August , 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.